PRINTED: 08/18/2009 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		295040	B. WIN			06/4	10/2000
	OVIDER OR SUPPLIER  H TRANSITIONAL RE	HABILITATION CENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102	1 06/1	10/2009
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F 000	INITIAL COMMEN	rs	F	000			
	a result of the annu- survey conducted a through 6/10/09.  The census was 91 was 26 sampled re	Deficiencies was generated as all Medicare recertification at your facility on 6/2/09  residents. The sample size sidents which included 3 d 7 unsampled residents.					
	by the Health Divis prohibiting any crim actions or other cla	onclusions of any investigation ion shall not be construed as ninal or civil investigation, ims for relief that may be rty under applicable federal,					
F 221 SS=D	483.13(a) PHYSIC.  The resident has the physical restraints in discipline or convenient.	encies were identified: AL RESTRAINTS  The right to be free from any mposed for purposes of the nience, and not required to medical symptoms.	F	221			
	by: Based on observat review, the facility f	NT is not met as evidenced ions, interview and record failed to assess the benefits of as restraints for 1 of 26					
	Findings include:						
	Resident #1						
LABORATORY		dmitted to the facility on 5/8/09, ER/SUPPLIER REPRESENTATIVE'S SIGNATUR	) DE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG	······································	06/1	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	<u>'</u>	20	REET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. .AS VEGAS, NV 89102	,	
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F 221	Hemorrhage, Convu Respiratory Failure, The resident's medic resident is severely or responsive. The nurse's notes for indicated that the resout and had to be resident was observed urine into his Foley belief were free of any.  On the morning of 6/observed with a hand.  On the morning of 6/observed without a high blood in his tracheos urine draining into the observed grasping hight hand.  During the morning of observed with a hand.  The Assistant Direct interview on 6/9/09, in necessary for the use Resident #1's clinical hand mittens to be used.	t included Traumatic Brain Isions, Ventilator Dependent Congestive Heart Failure. It is all record revealed the cognitive impaired and is non ident was also admitted with 4 is sores and a Foley catheter. It resident #1 dated 6/1/09, isident's Foley catheter was inserted.  2/09, Resident #1's Foley ed draining pinkish color restraints.  3/09, Resident #1 was id mitten on his right hand.  4/09, Resident #1 was is and mitten, presence of tomy tube and dark colored in Foley catheter bag.  6/4/09, Resident #1 was its tracheostomy tube with his in that a physician's order was its of hand mittens.  I record revealed no order for sed, nor was there any	F	221			
	hand mittens to be u						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 223 SS=D	facility did not assess for the use of hand m #1 from harming hims his Foley catheter or 483.13(b), 483.13(b), The resident has the sexual, physical, and punishment, and involuntary seclusion  The facility must not to or physical abuse, co involuntary seclusion  This REQUIREMENT by: Based on interviews a facility failed to ensur resident sexual abuse investigated for 1 of 2  Findings include: Resident #24  Resident #24 was an to the facility on 9/17/include Depressive D Blindness, Rheumato Syndrome, Shortness	or obtain a physicians order ittens to prevent Resident self by possibly pulling out tracheostomy tube.  1)(i) ABUSE  right to be free from verbal, mental abuse, corporal pluntary seclusion.  Use verbal, mental, sexual, reporal punishment, or  is not met as evidenced and document review, the e an alleged resident to e was identified and deforesidents (Resident #24).  87 year old male admitted 109, with diagnoses to isorder, Hypertension, Legal and Arthritis, Restless Legs of Breath, Osteoporosis		2221	DEFICIENCY)		
	and oriented times th  Record Review:  The Nurses Notes redocumentation:						

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F 223	episode of stroking a hallway, pt was firmly was not appropriate. angry and yelling & vapprehending him. Pon their behind while not to do that & pt statouch you or not"."  " 2/19/09 6:10 PM Pt close contact C (with attempting and witner from his chair to get gestured to hit staff C "2/26/09 5:20 PM Pt wheelchair and was station. Nurse asked blocking the entry. P to CNA (Certified Nu sitting at the nurse's CNA asked pt to repyelled out, "I want to witnessed by CNA (r that his remarks wou "I don't care that doe On 3/19/09 at 10:15 that a CNA notified h CNA he wanted to "be female breasts)" and " 3/19/09 2 PM Pt.(R by several staff mem (Resident #24's nam patient's (female) arron his crouch. (Resident entre contact in the contact in t	ent-Resident #24) had an female pt sitting along the y told not to do it because it Pt became very upset and verbally abusive to staff t also touches female staff their back is turned pt told ates "the hell who cares if I (Resident #24) getting in ) one female patient. Pt ssed by staff standing up closer to the other patient. Pt chis rt (right) hand."  (Resident #24) sitting on his blocking entry to nurse's pt to move back he is t refused to move and stated rsing Assistant) who was station, "I want to rape her" eat what he stated and pt rape her" Pt statements name) and waiter. Pt was told lid be reported and he stated, sn't change anything"."  AM, the nurse documented er that Resident #24 told the bite her (vulgar slang word for he would be good to her.  esident #24) was witnessed bers and other patients that	F	223			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
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F 223	female pt and his still patient taken away fr doing anything wrong "3/19/09 1800 (6:00 I reported to me that h #24's name) fondling female patient's brea hallway without staff RN (registered nurse name) Pt was advise patient."  The facility Abuse Pr 0301.00) effective da an alleged sexual incresident and alert/corconsensual or non-conot define when law called after investigated sexual abuse between consensual or non-consensual or non-consensual or non-consensual or non-consensual and alert and oriented or Interview:  On 6/10/09, the Adm coordinator) and the (DNS) indicated they incidents. The DNS in very friendly with the	owel while hands of the under the towel. Female om him. Patient denied g."  PM) Another male patient e had witnessed (Resident and messaging the same sts while sitting along the around. Incidents reported to supervisor (Employee #6's d to stay away from female  evention Policy (APM ate 10/01/05, does not define sident between an alert infused resident whether consensual. The policy does enforcement should be and substantiating en two residents whether consensual.  contained in the Nurse's arif there was one female or ents involved in the sexual ents were consensual or if the female residents were	F	223				

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	SUMMARY ST. (EACH DEFICIENCY REGULATORY OR I  Continued From page She indicated the star inappropriate behavior female staff members.  During the abuse prefacility staff on 6/4/09 five staff indicated the Supervisor if they with a sexual encounter.  483.15(a) DIGNITY  The facility must prommanner and in an envenhances each reside full recognition of his.  This REQUIREMENT by: Based on observation failed to ensure that cafforded to 4 of 26 resided to 5/9/09, the staff were resident's rooms with 2. On 6/2/09, 6/3/09, Residents #5, #6 and hop music playing on television was turned residents were non-vicine.	DVIDER OR SUPPLIER  H TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5  She indicated the staff never notified her of his inappropriate behavior with female residents or female staff members.  During the abuse prevention interviews with facility staff on 6/4/09, 6/5/09 and 6/9/09 five of five staff indicated they would report to the Nurse Supervisor if they witnessed two residents having a sexual encounter.  483.15(a) DIGNITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that dignity and respect was afforded to 4 of 26 residents (#5, #6, #11 and #18) and three unsampled residents.  Findings include:  Observations:  1. During the facility tour of the 100 Hall on 6/9/09, the staff were observed entering the resident's rooms without knocking.  2. On 6/2/09, 6/3/09, 6/4/09, and 6/5/09, Residents #5, #6 and #11 had loud pop and hip hop music playing on the radio while the television was turned on in their rooms. The residents were non-verbal and ventilator dependent and unable to voice their music	DVIDER OR SUPPLIER  H TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5  She indicated the staff never notified her of his inappropriate behavior with female residents or female staff members.  During the abuse prevention interviews with facility staff on 6/4/09, 6/5/09 and 6/9/09 five of five staff indicated they would report to the Nurse Supervisor if they witnessed two residents having a sexual encounter.  483.15(a) DIGNITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  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F 241	Continued From page	e 6	F	241			
	the rooms of Resider unsampled resident resident resident resident resident resident residence of tracheostomy changes Respiratory Therapis  4. On 6/2/09 at 12:50 an unsampled reside observed lying supines  5. During the morning one unsampled reside completely unclothed opened.						
	· ·	nt #18 indicated the staff on the door when entering					
	often had to change to rooms of the resident indicated the CNAs (changed the stations while they administra	rvities Director indicated she the music on the radio in the is on the 100 Hall. She Certified Nurse Assistants) to loud inappropriate music ted care to the residents. d music probably agitated ent residents.					
F 246 SS=D	observation of Reside indicated sometimes resident's room the n 483.15(e)(1) ACCOM	IMODATION OF NEEDS  tht to reside and receive	F	246			

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F 246	accommodations of in	ndividual needs and when the health or safety of	F	246			
	by: Based on observation	is not met as evidenced  n, the facility failed to ensure s were properly positioned.					
F 250 SS=D	three unsampled ven in Rooms 103B, 107B to be slumped down in against the side rails.  2. An unsampled resi observed sleeping in head slumped forward 4:30 PM.  483.15(g)(1) SOCIAL  The facility must proviservices to attain or not services.	ide medically-related social naintain the highest mental, and psychosocial	F	250			
	by:	is not met as evidenced nd record review, the facility I services assessed,					

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F 250	26 residents who disp behaviors, had family classifications. (Resident #24 Resident #24 Was and to the facility on 9/17/include Depressive Delindness, Rheumato Syndrome, Shortness and Esophageal Refluand oriented times the Interview:  On 6/3/09, the Admin previous Social Work and the new person had and the new person had before the start. Record Review  The Nurse's Notes for on 2/10/09, 2/17/09, 2/16 resident was sexuunknown number of for Tag F223). The note abusive and sexually members.	de recommendations for 3 of played inappropriate issues and incorrect dents #5, #12, #24).  87 year old male admitted 09, with diagnoses to isorder, Hypertension, Legal id Arthritis, Restless Legs of Breath, Osteoporosis ux. The resident was alert ree.  istrator indicated the er was no longer employed and started employment two of the survey.  The Resident #24 documented 2/19/09, 3/11/09 and 3/19/09 and 3/19/09 and semale residents (also see is revealed he was verbally suggestive to female staff entation concerning riors in the Social Service	F	250			

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F 250	Continued From pag	e 9	F	250			
	the facility on 5/8/09, Chronic Airway Obst Heart disease, Conv. Myocardial Infarction Use Disorder. The rea Coronary Bypass Con April 20, 2009. The from the hospital to the Record Review:  The Nurse's Notes does do resident's son gave how yield burns to his face and On 5/24/09, the resident's parking locity cigarette was given to the facility parking locity cigarette was given to the Nurse's Notes do 5/24/09 and 5/25/09, smelled of alcohol.  The Nurse's Notes for 5/16/09, indicated the remove the inebriate he became frustrated staff.  There were several in between Resident #1 son documented in the 5/16/09, 5/24/09 and 5/25/09 and 5/16/09, 5/24/09 and 5/16/09, 5/16/09, 5/16/09 and 5/16/09 and 5/16/09, 5/16/09 and 5/16/09 and 5/16/09, 5/16/09 and 5/16/09, 5/16/09 and 5/16/09, 5/16/09 and 5/16/09, 5/16/09 and	ated 5/16/09, indicated the nim a cigarette while on in the resident receiving arm (also see Tag F323). Hent was found smoking in twith oxygen in use, and the					

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F 250	Service Notes conce	ented evidence in the Social rning interventions used to uations that occurred during	F	250			
F 279 SS=E	the facility on 7/21/09 Anorexic Brain Dama Acute Respiratory Fa Contractures, History to Tracheostomy, Ve Hypertension.  A Quarterly Social Se indicated Resident #8 and was a full code.  The resident had an a in his medical record be a, "Class II" (no C resuscitation), no def 483.20(d), 483.20(k)( CARE PLANS  A facility must use the to develop, review ar comprehensive plan  The facility must deve plan for each residen objectives and timeta medical, nursing, and needs that are identifi assessment.	of Renal Failure, Attention Intilator Dependent, and ervice Note dated 4/29/09, 5 had no Advance Directive Advance Directive from 2008 that indicated he wished to PR (cardiopulmonary librillation).  1) COMPREHENSIVE  e results of the assessment d revise the resident's	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
		295040	B. WIN	IG_		06/10	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	highest practicable p psychosocial well-be §483.25; and any set be required under §4 due to the resident's §483.10, including the under §483.10(b)(4).  This REQUIREMENT by: Based on record revipolicy review, and intensure the plan of ca #9, #10, #13, #15, #2  Findings include: Resident #4 Resident #4 was a 8 the facility on 4/8/09, Cervical Fracture, Hi Gait, Parkinson Dise Otherwise Specified, Esophageal Reflux.  Record review:  Documentation in the indicated the resident following dates and sinjury: 1). 5/2/09 at 1850 (6)	ain or maintain the resident's hysical, mental, and ing as required under rvices that would otherwise 83.25 but are not provided exercise of rights under regist to refuse treatment.  T is not met as evidenced fews, documentation review, the facility failed to are for 7 of 26 residents (#4, 22, #24) were updated.  3 year-old male admitted to with diagnoses including Old story of Falls, Abnormality of ase, Mental Disorder Not Depressive Disorder, and  e facility's Nurse's Notes at incurred falls during the shifts with documentation of 150 PM) and suffered a skin leasuring 3 centimeters.  130 PM) 6:40 AM)	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE		
		295040	B. WING _		06/	06/10/2009	
	OVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	the left eye brow which the left eye brow which Review of the residentisk, dated 4/17/09, in fall risk related to a habnormality, Parkinst Depression, old Cervand is on psychotrop. Further noted on the documented fall on 5 of the Care Plan, it was reviewed and no occur. There were not to the resident's care changes following the 5/9/09 and 5/30/09. Review of the facility dated 5/2/09, indicate attempting to get up apparent fall occurre. There was no other focumentation in the available for review foccurred between 5/5. The Physician's Order of a Bed Al a fall preventive mear response to the residence in the residence in the residence in the residence.	and suffered a laceration ch required sutures.  Int's Care Plan for Falls/Fall indicated the resident was a listory of falls, gait on's disease, Dementia, vical Spine Fracture, Debility ic medications.  Care Plan, was a siz/2/09. On the second page ras noted that the care plan to changes to the plan will to other documented updates a plan and implemented to e 4 other falls between  Is Post Fall Assessment, and the death of the resident was out of bed to stand and the death of the additional falls which 19/09 and 5/30/09.  Post Fall Assessment are resident's record and for the additional falls which 19/09 and 5/30/09.  Post Fall Assessment are resident's bed as sure. This order was in lent's fall earlier during the re was no documented	F 279				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPI	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		295040	B. WIN	IG		06/10/2009	
	OVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	20	EET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	Log for May 2009, indocumented falls on There was no docume for the falls which occ 5/30/09.  Resident #9  Resident #9 was 82 yadmitted to the facilition 1/29/09, with diag Disorder, Chronic Ba Pain, History of Coro Post Percutaneous T Angioplasty, Diabete Record review:  Documentation in the indicated the resident following dates and so 1). 3/10/09 during the right hand and middle 1). 4/30/09 at 0340 (Stissue bruise around 2). 5/10/09 at 0645 (Stingle broken rib.  Review of the resident risk, dated 5/7/09, indicated to a hindependent beyond	s Monthly Incident/Accident dicated the resident had 5/2/09, 5/9/09, and 5/14/09. entation on the monthly log curred on 5/26/09 and vear-old female initially yon 1/22/09, and readmitted noses including Anxiety ck Pain, Anemia, Chest nary Artery Disease, Status ransluminal Coronary s, and Hypothyroidism.  If facility's Nurse's Notes t incurred falls during the hifts and injuries noted: e day shift and required a e finger X-ray.  B:450 AM) and suffered deep right eye.  B:45 AM) and suffered a	F	279			

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	TIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED		
		295040	B. WING		06/10/2009	
	OVIDER OR SUPPLIER	ABILITATION CENTER	2	REET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. .AS VEGAS, NV 89102	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	current prescribed me plan date. There was 3/10/09 and on 4/30/0 care plan.  The fall on 5/10/09 w plan, but no evidence There were two new following the fall on 5 reminders and a low recommendation for a during the interdisciple evident on the care p  The Physician Orders the order for a low to physician orders at the assessment did not relow bed and the psycrecommended during meeting.  Review of the facility' dated 4/30/09, indica attempting to ambula apparent fall occurred assessment that the however there was no record and evidence current care plan in p  Review of the Post Facility of	Care Plan was a /10/09. Additional led resident diagnoses and edications as of the care no evidence of the falls on 09, noted on the resident's as documented on the care of injury documented. interventions implemented /10/09, which were frequent to floor bed. A a psychiatric evaluation linary team meeting was not lan as an approach.  Is, dated 5/28/09, revealed floor bed. Review of the netime of the post fall eveal evidence of orders for chiatric evaluation in the Interdisciplinary team see to the bathroom and the did. It was noted on the bed was in a low position, on physician order in the of low bed in the resident's	F 279			

AND PLAN OF CO	EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	NSTRUCTION (X3) DATE SUF COMPLETI		
		295040	B. WIN	G		06/10/2009		
	DER OR SUPPLIER	ABILITATION CENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
ho ord call for the call for th	der or intervention re plan prior to 5/10 esident #10 esident #10 was a 6 mitted on 3/20/09, th diagnoses includations astrostomy, Chronic sease, Convulsions thout Behavior District Behavior D	o evidence of a physician documented in the current 0/09, and not until 5/28/09.  67 year-old male initially and readmitted on 4/20/09, ding Attention to cobstructive Pulmonary specially provided the provided the second of the company of the provided the second of the provided the	F	279				

	A. BUILD	DING	COMPLET	ED
295040	B. WING	i	06/10/2009	
NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	•	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
Review of the resident's Care Plan for physical mobility, impaired, dated 4/7/09, indicated the resident was a fall risk related to functional decline, unstable gait, and has diagnosis of Alzheimer Dementia. There was no documentation of evidence of the two previous falls on 3/22/09 and 3/24/09, which required the resident to be transferred out for evaluation.  Review of the Care Plan for Falls/Fall Risk, dated 4/15/09, indicated the resident was a fall risk related to impulsive behaviors, tries to be independent beyond capabilities, unsteady gait, Alzheimer Dementia, and medications which could contribute to falls.  Review of the Care Plan for Falls/Fall Risk related to Alzheimer Disease, dated 5/4/09, indicated the resident was a fall risk due to the same indications noted in the above 4/15/09 plan. Again there was no updates to the resident's care plan with the five falls the resident has incurred and any new interventions to prevent the possibility of future falls.  Further review of the two above aforementioned care plans had no evidence of five falls the resident incurred during the previous admission (3/22/09, 3/24/09) and the current admission (4/9/09, 4/10/09, 4/15/09). There was no indication of change with interventions that would possibly prevent further falls.  An attempt to review the facility's Post Fall Assessments for each fall was unavailable. There was no evidence of the assessments following a fall.	F 2	79		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLET	
		295040	B. WIN	IG _		06/1	0/2009
	OVIDER OR SUPPLIER  THANSITIONAL REH	ABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	Continued From page	e 17	F	279			
	she had not complete post fall investigation indicated that there we resident's falls. She are ported injuries due  Employee #12 acknot that the assessments facility in care planning Resident #13  Resident #13  Resident #13 was a second to the facility on 1/7/02/21/09 to Nathan Accidiagnoses including I Specified, Hyperlipide Fracture/Repair, Dep Disease, Dysphagia	added that there were no to the falls.  Weledged during the interview is following falls assist the ing.  92 year-old female admitted in items on the spice, with items of the spice, with items of the spice, with items of the spice in items of					
	Record review:						
	the resident incurred documented evidence 1). 1/16/09 during the 2). 2/12/09 during the unattended in the din Review of the resider risk, dated 1/14/09, in	e evening shift e evening shift while left					
	Parkinson, Depression	on, Anemia, Atrial fibrillation, hat could contribute to falls.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLETI	
		295040	B. WIN	IG		06/1/	0/2009
	OVIDER OR SUPPLIER	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 279	Continued From page	e 18	F	279			
	orders for X-rays of the lumbar spine series, the resident in a low						
	was no evidence of n documented on the c of the care plan revea change in plan of car	falls on 1/16/09 and re noted as no injury. There					
	1/16/09, indicated the resident's activity dur the resident's room. I assessment that the	resident was in a low bed der for low bed was written					
	2/12/09, indicated the	all Assessment, dated e resident was sitting in her ng room when the fall					
	indicated the residen	ation Report, dated 2/12/09, t was left unattended in the e fall occurred on 2/12/09.					
	Resident #15						
	to the facility on 4/30	55 year-old female admitted /09, with diagnoses including s, Recurrent, Secondary to					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SUF COMPLET	
	295040	B. WIN	IG		06/10/2009	
	ABILITATION CENTER	•	2	035 W. CHARLESTON BLVD.		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
Recurrent Cerebroval Acute renal Failure as on Hemodialysis, State Pneumonia, Fungal I Diabetes, Hypertensis Swelling.  Record review:  Review of the three Facontained in the reconstruction in the reconstruction in the reconstruction of the two Cates of the two	Post Fall Assessments and indicated the resident two falls on 5/4/09 and the facility had as an enabler and frequent assistance. The intervention fall was a X-ray due to the face on the floor. There was liditional or different ay prevent future falls.  In dated 5/7/09, noted the falls of the face on the floor. There was liditional or different ay prevent future falls.  In dated 5/7/09, noted the fall of the fall of the falls.  In dated 5/7/09, noted the fall of the falls.  In dated 5/7/09, noted the fall of the fall of the falls.  In dated 5/7/09, noted the fall of the fall of the falls.  In dated 5/7/09, noted the fall of the fall of the falls.  In dated 5/7/09, noted the fall of the falls.  In dated 5/7/09, noted the fall of t	F	279			
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR Recurrent Cerebrova Acute renal Failure a on Hemodialysis, Starneumonia, Fungal I Diabetes, Hypertensi Swelling.  Record review:  Review of the three Facontained in the recoincurred three falls of (5/4/09, 5/11/09,5/17 in the resident's bedratransfer.  Review of the two Cadated 5/4/09 and 5/7 the resident had incut 5/4/09, noted the firs 5/11/09. Following the moted on the plan that implemented siderail reminders to ask for following the second resident hitting her fano evidence of an adintervention which m  The second Care Plaresident's third fall or on the was to scheduthe resident new glast the second page of the which indicated no classification of the was to scheduthe resident new glast the second page of the which indicated no classifications.	CORRECTION  295040  COVIDER OR SUPPLIER  PH TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  Recurrent Cerebrovascular Accident, History of Acute renal Failure and Chronic Kidney Disease on Hemodialysis, Status Post Aspiration Pneumonia, Fungal Dermatitis, History of Diabetes, Hypertension, and Left Upper Extremity Swelling.  Record review:  Review of the three Post Fall Assessments contained in the record indicated the resident incurred three falls during the month of May 2009 (5/4/09, 5/11/09,5/17/09). All three falls occurred in the resident's bedroom while attempting to transfer.  Review of the two Care Plans for Risk of Falls, dated 5/4/09 and 5/7/09, noted all three falls that the resident had incurred. The Care Plan dated 5/4/09, noted the first two falls on 5/4/09 and 5/11/09. Following the resident's initial fall, It was noted on the plan that the facility had implemented siderails as an enabler and frequent reminders to ask for assistance. The intervention following the second fall was a X-ray due to the resident hitting her face on the floor. There was no evidence of an additional or different intervention which may prevent future falls.  The second Care Plan, dated 5/7/09, noted the resident's third fall on 5/17/09. Interventions noted on the was to schedule an eye examination to get the resident new glasses. A second notation on the second page of the plan was on 5/20/09, which indicated no change to the plan of care.	CORRECTION  IDENTIFICATION NUMBER:  A BUIL  295040  A BUIL  295040  B. WIN  COVIDER OR SUPPLIER  PH TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  Recurrent Cerebrovascular Accident, History of Acute renal Failure and Chronic Kidney Disease on Hemodialysis, Status Post Aspiration Pneumonia, Fungal Dermatitis, History of Diabetes, Hypertension, and Left Upper Extremity Swelling.  Record review:  Review of the three Post Fall Assessments contained in the record indicated the resident incurred three falls during the month of May 2009 (5/4/09, 5/11/09,5/17/09). All three falls occurred in the resident's bedroom while attempting to transfer.  Review of the two Care Plans for Risk of Falls, dated 5/4/09 and 5/7/09, noted all three falls that the resident had incurred. The Care Plan dated 5/4/09, noted the first two falls on 5/4/09 and 5/11/09. 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CONTIDER OR SUPPLIER  TH TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  Recurrent Cerebrovascular Accident, History of Acute renal Failure and Chronic Kidney Disease on Hemodialysis, Status Post Aspiration Pneumonia, Fungal Dermatitis, History of Diabetes, Hypertension, and Left Upper Extremity Swelling.  Record review:  Review of the three Post Fall Assessments contained in the record indicated the resident incurred three falls during the month of May 2009 (5/4/09, 5/11/09,5/17/09). All three falls occurred in the resident's bedroom while attempting to transfer.  Review of the two Care Plans for Risk of Falls, dated 5/4/09 and 5/7/09, noted all three falls that the resident had incurred. The Care Plan dated 5/4/09, noted the first two falls on 5/4/09 and 5/11/09. Following the resident's initial fall, It was noted on the plan that the facility had implemented siderails as an enabler and frequent reminders to ask for assistance. The intervention following the second fall was a X-ray due to the resident hitting her face on the floor. There was no evidence of an additional or different intervention which may prevent future falls.  The second Care Plan, dated 5/7/09, noted the resident's third fall on 5/17/09. Interventions noted on the was to schedule an eye examination to get the resident new glasses. A second notation on the second page of the plan was on 5/20/09, which indicated no change to the plan of care.	CORRECTION    DENTIFICATION NUMBER: 295040   B. WING   B	COMPLET  295040    STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTOR BLVO. LAS YEAGS, NV 89102    SUMMARY STATEMENT OF DEPOSITIONS IN PRESENT OF DEPOSITIONS IN PROSENT OF DEPOSITIONS IN PROSENT OF DEPOSITIONS IN PRESENT OF DEPOSITIONS IN PROSENT

295040 B. WING 06/10/2	/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2035 W. CHARLESTON BLVD.  LAS VEGAS, NV 89102	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Resident #22 was a 69 year-old male admitted to the facility on 5/2/09, with diagnoses including Congestive Heart Failure Not Otherwise Specified, Insomnia, Acquired Hypothyroidism, Spasm of Muscle, Hypertension, Status Post Amputee Below Left Knee, Gangrene, Status Post Amputee Dether Toe, and Diabetes Mellitis II Uncontrolled.  Documentation review: Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident incurred two falls soon after his admission on 5/2/09. Both falls (57/709, 5/8/09) occurred while the resident was in his room. The log did not contain any corrective actions corresponding to the two falls.  Record review: Review of the initial Fall Risk Assessment, dated 5/2/09, rated the resident with a total score of "5" (10 and above is high risk). The resident has a incurred an amputation below the right knee and fourth toe to left foot with indications of additional amputations as noted in a 6/1/09 Doctor's Progress Note during a wound follow-up visit.  Review of the two Care Plans for Risk for Falls, dated 5/7/09 and 5/11/09, indicated various facility approaches with no new interventions noted following the second fall.  The Care Plan, dated 5/7/09, noted as a facility approach was to maintain the bed at the "lowest position". However, it was noted in a Physician Order on 5/28/09 to place the resident in a "low bed for safety" and "activity = W/C (wheelchair), and no wt. (weight) bearing to if (left) leg.," This order was 20 days following the second fall.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLET		
		295040	B. WIN	IG		06/10/2009		
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. .AS VEGAS, NV 89102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 279	any new changes or fall and after the new Resident #24  Resident #24 was ar to the facility on 9/17 Cellulitis Not Otherw Disorder, Mental Dis Otherwise Specified, Arthritis, restless Legantibiotics, Shortness Reflux, Hyperlipidem and Osteoporosis Not Issue #1  Record review:  Review of the facility admission on 9/17/03 resident had incurred 1). 10/19/08, during 02). 3/10/09, during the complained of heada 5). 4/27/09, during the skin tear. 6). 5/20/09, during the Review of the reside 12/24/08, noted falls 10/19/08, 3/10/09, 3/1	both plans did not indicate updates following the second physician orders on 5/28/09.  In 88 year-old male admitted 1/08, with diagnoses including ise Specified, Depressive order, Hypertension Not Legal Blindness, rheumatoid gyndrome, Long-Term Use is of Breath, Esophageal is Not Otherwise Specified, of Otherwise Specified.  I's Nurse's Notes since 8, revealed several falls the did as shift and shift are evening shift are evening shift are evening shift and suffered in e day shift in the day shift and suffered in the resident incurred on 1/21/09, and 4/27/09. The care dates following the falls on	F	279				

NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES  RECOLATORY OR LSC IDENTIFYING INFORMATION)  FRETTIX TAG  CONTINUED From page 22  Further review of the plan revealed on the second page indicated no new changes or updates occurred following the early falls until seven days after the resident's assistance. *Also, noted on the second page of the plan was treatment to the resident's skin tear.  Policy review:  It was indicated in the facility's Fall Prevention that the facility would assess resident for the falls would identify the reason for the fall and would assist in the preparation of a plan of care which could reduce the potential for future falls.  It was indicated under the purpose subsection of the policy, that all residents would receive a "prompt assessment and treatment immediately following any fall or injury by the appropriate health professional."  It was indicated the facility's Fall Prevention, that under procedure #20. "The care plan will be updated, post fall, identifying the all and goals and approaches to reduce the potential of future recocurrence."		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF	
ST JOSEPH TRANSITIONAL REHABILITATION CENTER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER  INC. 10 SAY REAS, NY 89102  ID PROVIDERS PLAN OF CORRECTION (REACH PROPIDERATE STATE)  REGULATORY OR USC IDENTIFYING INFORMATION)  F 279  Continued From page 22  Further review of the plan revealed on the second page indicated no new changes or updates occurred following the early falls until seven days after the resident's fall on 4/2005. The intervention indicated was ".frequent verbal reminders to ask for assistance." Also, noted on the second page of the plan was treatment to the resident's skin tear.  Policy review:  It was indicated in the facility's Fall Prevention that the facility would assess resident for the risk of falls and to follow-up and evaluate falls in order to assess the resident's condition. It further indicated that the assessment of the falls would identify the reason for the fall and would assist in the preparation of a plan of care which could reduce the potential for future falls.  It was indicated under the purpose subsection of the policy, that all residents would receive a "prompt assessment and treatment immediately following any fall or injury by the appropriate health professional."  It was documented under the procedure subsection of the facility's Fall Prevention, that under procedure #14, "the nursing "Post Fall Assessment" will be completed by the charge nurse within 24 hours to assist in identifying the control of the procedure #14, "the nursing "Post Fall Assessment" will be completed by the charge nurse within 24 hours to assist in identifying the all identifying the approaches to reduce the potential of future recocurrence."			295040	B. WIN	IG		06/1	0/2009
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279  Continued From page 22  Further review of the plan revealed on the second page indicated no new changes or updates occurred following the early falls until seven days after the resident's fall on 4/20/09. The intervention indicated was "frequent verbal reminders to ask for assistance." Also, noted on the second page of the plan was treatment to the resident's skin tear.  Policy review:  It was indicated in the facility's Fall Prevention that the facility would assess resident for the risk of falls and to follow-up and evaluate falls in order to assess the resident's condition. It further indicated that the assessment of the fall and would assist in the preparation of a plan of care which could reduce the potential for future falls.  It was indicated under the purpose subsection of the policy, that all residents would receive a "prompt assessment and freatment immediately following any fall or injury by the appropriate health professional."  It was documented under the procedure subsection of the facility's Fall Prevention, that under procedure #20, "The care plan will be updated, post fall, identifying the fall and goals and approaches to reduce the potential of future reoccurrence."  It was further documented in the policy under procedure #14, " the nursing "Post Fall Assessment" will be completed by the change nurse within 24 hours to assist in identifying			ABILITATION CENTER	'	2	2035 W. CHARLESTON BLVD.		
Further review of the plan revealed on the second page indicated no new changes or updates occurred following the early falls until seven days after the resident's fall on 4/20/09. The intervention indicated was "frequent verbal reminders to ask for assistance." Also, noted on the second page of the plan was treatment to the resident's skin tear.  Policy review:  It was indicated in the facility's Fall Prevention that the facility would assess resident for the risk of falls and to follow-up and evaluate falls in order to assess the resident's condition. It further indicated that the assessment of the falls would identify the reason for the fall and would assist in the preparation of a plan of care which could reduce the potential for future falls.  It was indicated under the purpose subsection of the policy, that all residents would receive a "prompt assessment and treatment immediately following any fall or injury by the appropriate health professional."  It was documented under the procedure subsection of the facility's Fall Prevention, that under procedure #20, "The care plan will be updated, post fall, identifying the fall and goals and approaches to reduce the potential of future reoccurrence."  It was further documented in the policy under procedure #14, "the nursing "Post Fall Assessment" will be completed by the charge nurse within 24 hours to assist in identifying	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
contributing factors to the event." And indicated in procedure #18, that the information obtained from	F 279	Further review of the page indicated no ne occurred following the after the resident's faintervention indicated reminders to ask for the second page of the falls and to follow-to assess the resider indicated that the assidentify the reason for the preparation of a preduce the potential the policy, that all resign prompt assessment following any fall or in health professional."  It was documented usubsection of the facunder procedure #20 updated, post fall, ideand approaches to refreeccurrence."  It was further docume procedure #14, "the Assessment" will be nurse within 24 hours contributing factors to	plan revealed on the second by changes or updates e early falls until seven days all on 4/20/09. The days "frequent verbal assistance." Also, noted on the plan was treatment to the days assess resident for the risk up and evaluate falls in order assessment of the falls would be for future falls.  The purpose subsection of the sidents would receive a and treatment immediately and treatment immediately injury by the appropriate the potential of future fall and goals educe the potential of future fall completed by the charge is to assist in identifying the event." And indicated in the policy under the event." And indicated in the policy of the event."	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		295040	B. WIN	IG		06/1	0/2009
	OVIDER OR SUPPLIER  THE TRANSITIONAL REP	ABILITATION CENTER	'	20	EET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102	,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	JLD BE	(X5) COMPLETION DATE
F 279	Issue #2  Record Review:  The Nurses Notes redocumentation:  "2/10/09 7-3 Pt (patiepisode of stroking a hallway, pt was firml was not appropriate angry and yelling & apprehending him. Fon their behind while not to do that & pt st touch you or not"."  "2/19/09 6:10 PM Pt close contact C (with attempting and withe from his chair to get gestured to hit staff of "2/26/09 5:20 PM Pt wheelchair and was station. Nurse asked blocking the entry. Ft o CNA (Certified Nusitting at the nurse's CNA asked pt to repyelled out, "I want to witnessed by CNA (that his remarks wou" I don't care that doe"	evealed the following  ent-Resident #24) had an a female pt sitting along the y told not to do it because it. Pt became very upset and verbally abusive to staff et also touches female staff et their back is turned pt told ates "the hell who cares if I  (Resident #24) getting in an one female patient. Pt essed by staff standing up closer to the other patient. Pt C his rt (right) hand."  (Resident #24) sitting on his blocking entry to nurse's a pt to move back he is the refused to move and stated arising Assistant) who was station, "I want to rape her" eat what he stated and pt rape her" Pt statements aname) and waiter. Pt was told all did be reported and he stated, esn't change anything"."	F	279			
	On 3/19/09 at 10:15	AM, the nurse documented					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF	
		295040	B. WIN	IG	<del> </del>	06/1	0/2009
	OVIDER OR SUPPLIER	ABILITATION CENTER	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	CNA he wanted to "b female breasts)" and " 3/19/09 2 PM Pt.(Roby several staff mem (Resident #24's nampatient's (female) arm on his crouch. (Resident female) arm on his crouch. (Resident female pt and his still patient taken away from doing anything wrong "3/19/09 1800 (6:00 Freported to me that h #24's name) fondling female patient's breat	er that Resident #24 told the ite her (vulgar slang word for he would be good to her.  esident #24) was witnessed bers and other patients that e) is holding another in & hand and he had them ent #24's name) was e became very upset and he owel while hands of the under the towel. Female om him. Patient denied it."  PM) Another male patient e had witnessed (Resident and messaging the same ists while sitting along the	F	279			
F 314 SS=G	RN (registered nurse name) Pt was advise patient."  The Comprehensive #24 contained no dor resident's inappropriatemale residents and inappropriateness to facility.  483.25(c) PRESSUR  Based on the compreresident, the facility who enters the facility does not develop preindividual's clinical cotthey were unavoidab	vards female staff at the	F	314			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		295040	B. WIN	۱G _		06/1	0/2009
	OVIDER OR SUPPLIER	ABILITATION CENTER	•	Sī	TREET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	1 00.1	0/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 314	prevent new sores fro	nealing, prevent infection and om developing.	F	31	4		
	by: Based on observation interview, the facility to 26 residents (#16) was	is not met as evidenced  n, record review and failed to ensure that 1 out of as properly assessed and the development of a sacral					
	Findings include:						
	Resident #16						
	to the facility on 3/16/ Hypothyroidism, Oste Embolism/Infarction,	86 year old female admitted 09, with diagnoses including coporosis, Pulmonary Venous Thrombosis, Atrial and Urinary Track Infection.					
	Record Review:						
	resident has a history including a status pos compression fracture living with her husbar facility. It was noted the	I 3/25/09, indicated the of multiple diagnoses st fall with 70% T12. Prior to her fall she was and at an assisted living					
	indicated, a plan for the	sical Examination further he resident to receive a ation and the patient would					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG		06/1	0/2009
	ROVIDER OR SUPPLIER PH TRANSITIONAL REH	ABILITATION CENTER	'	203	ET ADDRESS, CITY, STATE, ZIP CODE 5 W. CHARLESTON BLVD. S VEGAS, NV 89102	, ,	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Consultation dated 3 alert and oriented tin functional mobility, a self-care.  It was further indicate to continue physical to work on bed mobi self care, and activiti Initial Nursing Admis 3/16/09 at 1700 (5:00 resident's skin was wand there was no sig skin breakdown obseand heels.  An Initial Admission indicated the resident areas. It was indicated pressure reduction n implemented and cirrositioning pillows an mattress.  It was indicated in th Set, admission asset the resident's cogniti modified independer situations). It was do resident's physical furequired extensive a physical assist (3/3) indicated in the asset	n the resident's Rehabilitation 1/19/09, that the resident was nest three, but has impaired ctivities of daily living and 1/19/09, that the consultation, a plan therapy, occupational therapy lity, bed-to-chair transfers, es of daily living.  Sion and Assessment, dated 1/19/19, indicated the within normal limits (WNL) gins of decubitus ulcers or erved at the resident's coccyx.  Skin Check, dated 3/17/09, at had no wounds or open ed on the document that heasures would be cled on the document were and a pressure reduction.  The resident's Minimum Data assent dated 3/23/09, that we skills was noted as note (some difficulty in new cumented under the unctioning that the resident sesistance with 2+ persons for bed mobility. Also, assment the resident would ence with 2+ persons for transfers.	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		295040	B. WING		06/	10/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CO 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 314	observed during the implemented under spressure relieving depreventive or protect.  The Resident Assess triggered for a potent the resident's diminismon documented care discovery of stage 3 to address the potent.  Physician orders, dat to "Cleanse deep tiss wound cleanser, pat order indicated that the daily and dressing change to the plan or repositioned prior to tissue injury of the Cochange to the plan or reposition was marked. It was indicated in the Review document, dideveloped a deep tis 4/1/09 measuring (in purple and maroon condicated that the cur in-place were a presspillows for positioning noted under staff recoplace the resident on start prostat.	d no presence of ulcers first 14 days and treatments kin treatment section were vice for bed and other	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		295040	B. WING		06/1	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REF	IABILITATION CENTER	20	EET ADDRESS, CITY, STATE, ZIP CODE 135 W. CHARLESTON BLVD. AS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Management Review revealed two new de and left posterior he measure of the injur measured 1.5 X 1.5 bed was 100% marcoposterior heel was n X intact blister with warroon.  On 5/22/09, it was in management update wound was measured undermined which w 20% purple.  There was no docum revealed a physiciar the resident at a cerchange in the reside which noted a turn a assist in the healing.  Observations:  Between the dates of 6/9/09 thru 6/10/09, the resident spent the afternoons in bed in Pillows were observed resident between the rail. There was no of indicated the resider repositioned to one strelieve pressure off specifically the Coccontrol of the control of the coccontrol of the coccontr	w document, dated 4/17/09, sep tissue injuries to the right els. It was indicated that the y to the left heel was X intact blister with wound from the injury to the left oted to measured at 2.0 X 3.0 wound bed was 100%  Indicated during a wound that the resident's Coccyx ed to be 7.0 X 2.4 X was 60% yellow, 20% red, and the interest of the coccyx wound.  In order to turn and reposition that in rate, even following the ent's Plan of Care on 4/1/09, and repositioning approach to of the Coccyx wound.  In 6/2/09 thru 6/5/09 and observations indicated that the majority of the morning and the same supine position. The entity of th	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	G		06/1	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	•	20	EEET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Additional observation transferred to a whee	to the facility dining room.  ns of the resident being	F	314			
	physician acknowledg	, the facilities wound care ged that the resident's Coccyx occurred following ity.					
	"for the most part w hour." The employee the resident up each	, Employee #10 indicated e shift the resident once an also indicated they now get day for a couple of hours rived, pillows were placed on ent.					
	that they have turned residents. She indicate	ted that there wasn't a note when residents were					
F 318	that she should have couldn't remember be	, Resident #16 indicated received more therapy and eing turned to one side to pressure off her bottom.  OF MOTION	F	318			
SS=D	resident, the facility methods with a limited range of	and services to increase or to prevent further					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	1G _		06/1	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	<b>,</b>	:	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		<u>-</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 318	Continued From pag	e 30	F	318	3		
	by: Based on observation review, the facility fair residents received se	r is not met as evidenced ns, interviews and record led to ensure 3 of 26 ervices to prevent further motion (Residents #5, #6,					
	Findings include:						
	Resident #5						
	the facility on 7/21/08 Anoxic Brain Damage Comatose State, Res Cardiac Arrest, Conv Hypertension and Co	9 year old male admitted to 8, with diagnoses to include e, Encephalopathy, spiratory Failure, Sudden ulsions, Diabetes Mellitus, entractures, Attention to ntilator (Vent) Dependent.					
	observed lying supine hands closed against observed on 6/2/09 it 11:00 AM, 2:00 PM at the survey in the more hands tightly clutched	on 6/2/09, the resident was e in bed with both contracted this chest. The resident was in the afternoon; 6/3/09 at and 4:30 PM; and all days of thing and afternoon with his diagainst his chest. There ice to prevent the resident's miskin break down.					
	Resident #6						
		3 year old male admitted to 5, and readmitted on 4/9/09,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		295040	B. WIN	IG _		06/10	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	'	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 318	with diagnoses to ince Failure, Anoxic Brain Injury, Hypertension, Attention to Gastrosto Convulsions, History Dependence.  During the initial tour observed lying on his beneath his torso. The were contracted. The 6/2/09, 6/3/09, 6/4/09 4:30 PM. The resider days lying in bed with clutched. There was resident's contracted down.  On 6/5/09 at 9:30 AM were interviewed com prevented Residents breakdown on the pa hands. Employee #19 towel or a carrot devi resident from digging On 6/5/09 in the after indicated she though a rolled hand towel o contracted hands to p  On 6/5/09 in the after Nursing Services was needed to use a rolle with contracted hand	Damage, Traumatic Brain Pressure Ulcer of Buttocks, omy, Anxiety State, of Septicemia and Ventilator  on 6/2/09, the resident was left side with his left arm e resident's both hands resident was observed on at 11:00 AM, 2:15 AM and at was observed on these his contracted hands no assistive device in the hands to prevent skin break  I, Employees #15 and #16 cerning how the facility #5 and #6 from skin Ims of their contracted indicated a rolled up hand ce is used to prevent the into their palms.  Incoon, Employee #3 at an order was necessary for recarrot between a resident's prevent skin break down.	F	318			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET  OPLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET						
		295040	B. WIN	IG_	<del> </del>	06/1	0/2009
	OVIDER OR SUPPLIER	ABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	00/1	5/ <b>2</b> 000
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	9/7/07, with diagnose Respiratory Failure, It Hemorrhage, Convul Gastrostomy, Pressul Ventilator Dependent During the initial tour observed lying supinhands lying on his chaplints observed on his contracted hands 6/3/09 at 10:30 AM, this bedside table. Or resident was observed with his contracted hands 6/4/09 at 11:00 AM a his splints in place with his contracted hands the splints.  On 6/5/09 in the after indicated the Restoration She indicated the Ce (CNA) take the splint indicated they put the are suppose to check the splints are on corror on 6/5/09 in the after Therapy indicated the splints often slide down hands to close. He in the resident for another the splints of the splints of the splints of the splints of the slide down hands to close. He in the resident for another the splints of	year old male admitted on es to include Acute Encephalopathy, Intracranial sions, Attention to are Ulcer, Hypertension and t.  on 6/2/09, the resident was ee in bed with his contracted est. There were 2 blue his bedside table. On 6/2/09 resident was observed with inside the blue splints. On the residents splints were on 6/3/09 at 4:00 PM, the ed with his splints in place ands inside the splints. On and 2:30 PM, the resident had ith his contracted hands  The moon, Employee #3 active Aides apply the splints. For tiffied Nursing Assistants are off to do morning care. She em back on incorrectly We are every 2 hours to make sure frectly.  The moon, the Director of the fingers of the hand should a splint is applied to a indicated Resident #11's win allowing his contracted adicated he would re-evaluate		318			
F 323	483.25(h) ACCIDEN	TS AND SUPERVISION	F	323			

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG	<del> </del>	06/10	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 1035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	30/10	5/ <b>2</b> 000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323 SS=H	as is possible; and ea	ure that the resident as free of accident hazards	F	323			
	by: Based on observation review, the facility fair residents received ac assistive devices to possistive devices to possistive devices.  Residents #12, #4, # Findings include: Resident #12 Resident #12 was a street facility on 5/8/09, Chronic Airway Obstruert disease, Converse review.	dequate supervision and brevent accidents and falls #9, #10, #13, #15, #22, #24).  75 year old male admitted to with diagnoses to include ruction, Chronic Ischemic ulsions, Hypertension, Old					
	Use Disorder. The real Coronary Bypass Connection April 20, 2009. The from the hospital to the Record Review:  The Nurse's Notes for the following:	or Resident #12 documented PM) 1820 (6:20 PM) Family					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	COMPLETE	
		295040	B. WIN	IG_		06/10	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	<b>,</b>	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	(with) a burnt to face smoking cigarettes."  "5/16/09 1830 ( 6:30 outside smoking with cigarette burns pt fact the pt nose. Pt son g smoke. Pt son smell pain. Tylenol given 6 mouth) given. MD (m son was calling supe Because we didn't set Unable to know the aburn. Pt son (name) Station (300) O2 (oxy (registered nurse). Pt and R (right) arm loo  "5/16/09 2000 (8:00 If #12's name), was brown to face and har outside. Pt's face was mustache burnt. Pt was tranged to reduce the could have wheelestreet"  "Pt was tranged to reduce the could have wheelestreet"  "5/24/09 2300 (11:00 If #12) earlier with son previously mentioned pt. in his wheelchair or cigarette"	2) to the nursing station C and head, suffered while (no signature by nurse)  PM) Pt. (Resident #12) was family member The e and the canula melted in ave cigarette to the pt to of alcohol. Pt complain of 50 mg (milligrams) PO (by edical doctor) notified. Pt rvise (?) stupid nurses and Pt to hospital right away. Ctual place when the Pt got brought Pt to the Nurse (regen) given by RN around mouth looks black as red."  PM) This patient (Resident bught to the nurse by son in stating that pt. suffered and while smoking cigarette is noted to be black as also complaining of burnt at son (name) (who smells or irritated and was calling the liots and retarded stated that the determinant of the state of the father across the series of the series	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER:  A. BUILE			PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG		06/1	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
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F 323	Resident #12's Neuronducted at Sunrise indicated "He (Ressmoker who had last admission"  Resident #12's Disch Hospital dated 5/8/05 Diagnoses: Long sta Multiple Myocardial I Breath (SOB), Hype Cerebrovascular Accresidual left arm weat Endarterectomy and A Facility Social Serva Resident #12 dated 8"MEDICAL HISTOR to 5/8/09 CHF (Cong Disease, Multiple MI H/O (history of) CVA Mellitus) H/O smokin consumption, seizure OF: Comments: Forgon A Facility Activities In Resident #12 dated 8"Smoker" in the top r "Diagnosis Hx (histographic and the seizure of the seizure	29, indicated "Patient has ir"  cological Consultation is hospital dated 4/11/09, ident #12) proved to be a smoked prior to  consider the smoked prior to smoked prior the smoked prior to  consider the smoked prior the sm	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		295040	B. WIN	1G		06/1/	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	'	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	,	
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F 323	#12 dated 5/9/09, inchand corner, "non-sr Area was crossed or information.  A Resident Smoking #12 and the facility of following information.  1. The resident agreeretain all smoking ite. 2. The resident under would be returned to. 3. The resident agrees moking items with a 4. The resident agreematerials with anothe 5. The resident agree to the charge nurse a 6. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The resident undecontract to control him would give up the prismoking material.  7. The safety of facility.	Assessment for Resident dicated in the upper right noker." The Assessment and not filled in with  Contract between Resident ated 5/21/09, indicated the :  ed to allow the facility to ms.  restood his smoking items him for smoking privileges ed not to share any of his another resident.  ed to return all smoking items at the nurse's station.  restood if he violated this sown smoking material he vilege to control his own  restood this agreement to all the residents of the  the agreement dated  Policy dated 3/05 and cated the following:  assessed for their ability to nission, quarterly and significant change in condition	F	323			

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	ROVIDER OR SUPPLIER PH TRANSITIONAL REH	ABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 1035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	00/1	57 <b>2</b> 000
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F 323	material will have sur with staff.  6. Residents and fan Smoking Policy and of admission and per Resident Council, Cameetings.  There was no docum Resident #12 had que member of the resident stopped smoking. The assess Resident #12 could smoke unsuper of understanding the oxygen in use.  The Admission Pack no information for the concerning smoking. Interviews:  On 6/4/09 in the after indicated Resident # courtyard in the cent indicated there were when the resident was out about the incident took him to the nurse resident was burned indicated the son madesignated smoking	ed as not safe with smoking pervised smoking privileges inilies will be informed on the Smoking Contract at the time riodically reviewed at are Plan and Family Council inentation that indicated it smoking or that any ent's family indicated he had be facility failed to properly it to obtain whether or not he rivised or if he was capable seriousness of smoking with et for the facility contained in family of the residents.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		295040	B. WING _		06/·	10/2009	
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	ST	TREET ADDRESS, CITY, STATE, ZIP COD 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	months. She indicate for a cigarette and he said I am guessing I there was no way of was going to give hin was asked it she kne history of heavy smol family informed on ac oxygen use and smo the door of the rooms. Administrator and En Resident #12 and his visits after the incider indicated after the reagain in the parking I restricted the son's viz:00 PM. Employee #had quit smoking for non-smoker, there was smoke safety. When he quit, she indicated notes.  There was no docum medical record that is stopped smoking.  Resident #4  Resident #4  Resident #4  Resident #4  Resident #4  Resident #7  Resident #4  Resident #4	and had not smoked for six digital the resident asked the son a gave it to him. She then was not here. She indicated knowing the resident's son a cigarette. Employee #12 with the resident had a long king and was he and the dimission about the danger of king. She indicated, "It is on a sit's common sense." The imployee #12 were asked why as son did not have supervised and on 5/16/09. Employee #12, sident was found smoking of on 5/24/09, the facility sitations from 10:00 AM to the facility sitations from 10:00 AM to the facility sitations from 10:00 AM to the facility sitations from 10:00 and the	F 32.	3			

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F 323	Continued From pag	e 39	F 323	3			
	evidence of an old or Parkinson's disease, noted in the initial explan was to initiate reclosely.  Prior to admission to seen at Nellis Air Bacomplaints of headartransferred to Sunris Center for further wo a possible cervical frhealing fracture.  The Fall Risk Assess revealed that the resmeasured at a score at high risk for falls of current clinical condiction assessment, that a serpresents a high ris.  The Side Rail Assessindicated the resident assistance to transfer assist with bed mobil device, continent of leasist (consider planneeds), and restless.  It was further noted if the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased monitoring the side rails up at all the interventions to be increased.	and a history of falls, with ervical #1 fracture, and gait abnormality. It was amination that the resident's ehabilitation and monitor very  this facility, the resident was see following a fall and ches. Than the resident was e Hospital and Medical rk-up following a discovery of acture which was an old  sment, dated 4/18/09, ident's fall status was of "18", placing the resident ue to a history of falls and his tion. It was noted on the core of "10" or above k for the potential for falls.  sment Tool, dated 4/15/09, it required partial or total r, required staff cueing or lity with or without assistive bowel/bladder with or without to accommodate toileting in bed.  In the rail assessment that we implemented were and the resident will have					
	Documentation in the	e raciitty's inurse's Notes					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	OVIDER OR SUPPLIER  H TRANSITIONAL REHA	ABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	1 00/1	0/2003
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		_D BE	(X5) COMPLETION DATE
F 323	following dates and s 1). 5/2/09 at 1850 (6: tear of about 3 centin 2). 5/9/09 at 1930 (7: 3). 5/14/09 at 0640 (6: 4). 5/26/09 at 1500 (3: 5). 5/30/09 at 4:45 Pl 6). 6/4/09 following la laceration to the left of Review of the resider risk, dated 4/17/09, in fall risk related to a h abnormality, Parkinso Depression, old Cerv and is on psychotrop  Further noted on the documented fall on 5 On the second page noted that the care p changes to the plan of other documented up plan and implemente other falls between 5  Review of the facility dated 5/2/09, indicate attempting to get up apparent fall occurred  There was no other following to which occurred between Additional post fall do	t incurred falls during the shifts with injuries: 50 PM) and suffered a skin meters to left arm. 30 PM) 5:40 AM) 3:00 PM) Munch and suffered a eye brow requiring sutures. Int's Care Plan for Falls/Fall indicated the resident was a istory of falls, gait on's disease, Dementia, vical Spine Fracture, Debility ic medications.  Care Plan was a si/2/09 with no apparent injury. of the Care Plan, it was lan was reviewed and no will occur. There were no odates to the resident's care id changes following the 4 /9/09 and 5/30/09.	F	323			
	asinty or an interestin	100 Policy Was 12 Hour					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	295040	B. WIN	IG		06/1	0/2009	
	ABILITATION CENTER	'	203	5 W. CHARLESTON BLVD.		<u></u>	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
neurological checks: The resident incurred the month of May 20 revealed actual neuron the facility's Neurological Comment. However, completed following (not fulfilling the 72 h A Physician's Order order for a Bed Alarm fall preventive measuresponse to the resident's care placed for the resident's bed as a factor of the facility Log for May 2009, in documented falls on There was no documfor the falls which octor of the facility Fall Preventive falls.  Observations:  Between 6/2/09 and observable signs that alarm applied to his facility to the facility that the falls.	following an unwitnessed fall. If five separate falls during 09. Only two of the falls ological assessments noted ological Assessment the checks were partially the 5/2/09 and 5/9/09 falls our procedure). If dated 5/26/09, indicated an infor the resident's bed as a ure. This order was in lent's fall during the day on indo documented evidence to roach was documented on an or implemented to the fall preventive device.  W:  Is Monthly Incident/Accident dicated the resident had 5/2/09, 5/9/09, and 5/14/09. Inentation on the monthly log curred on 5/26/09 and  Pention policy, the post fall ized in determining and inches to assist in preventing  6/4/09, there was no t the resident had a bed oed. The resident incurred	F	323				
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR DEPARTMENT OF THE PROBLEM OF	CORRECTION  DENTIFICATION NUMBER:  295040  COVIDER OR SUPPLIER  TH TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 41  neurological checks following an unwitnessed fall. The resident incurred five separate falls during the month of May 2009. Only two of the falls revealed actual neurological assessments noted on the facility's Neurological Assessment document. However, the checks were partially completed following the 5/2/09 and 5/9/09 falls (not fulfilling the 72 hour procedure).  A Physician's Order , dated 5/26/09, indicated an order for a Bed Alarm for the resident's bed as a fall preventive measure. This order was in response to the resident's fall during the day on 5/26/09. There was no documented evidence to support that this approach was documented on the resident's care plan or implemented to the resident's bed as a fall preventive device.  Documentation review:  Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident had documented falls on 5/2/09, 5/9/09, and 5/14/09. There was no documentation on the monthly log for the falls which occurred on 5/26/09 and 5/30/09.  Per facility Fall Prevention policy, the post fall assessments are utilized in determining and implementing approaches to assist in preventing future falls.	A BUIL  295040  IDENTIFICATION NUMBER: A BUIL  295040  IDENTIFICATION NUMBER: B. WIN  A BUIL  295040  IDENTIFICATION NUMBER: A BUIL  295040  IDENTIFICATION NUMBER: B. WIN  IDENTIFICATION NUMBER: A BUIL  295040  IDENTIFICATION NUMBER: B. WIN  IDENTIFICATION NUMBER: A BUIL  295040  IDENTIFICATION NUMBER: B. WIN  IDENTIFICATION NUMBER: B. WIN  IDENTIFICATION NUMBER: A BUIL B. 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The resident incurred two another fall on 6/4/09 during apparent self	CONTIDER OR SUPPLIER  TH TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDEMTIFYING INFORMATION)  Continued From page 41  The resident incurred five separate falls during the month of May 2009. Only two of the falls revealed actual neurological assessments noted on the facility's Neurological assessment document. However, the checks were partially completed following the 5/2/09 and 5/3/09 falls (not fulfilling the 72 hour procedure).  A Physician's Order , dated 5/26/09, indicated an order for a Bed Alarm for the resident's bed as a fall preventive measure. This order was in response to the resident's fall during the exident's bed as a fall preventive measure. This order was in response to the resident's Bed as a fall preventive device.  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LAS VECAS, NV 39102  SUMMARY STATEMENT OF DEFICIENCIES  PROVIDERS PLAN OF CORRECTION  FAGS  CROSS-REPERENCED TO THE APPROPRIATE  DEFICIENCY  FAG  CROSS-REPERENCED TO THE APPROPRIATE  DEFICIENCY  FAG  PROVIDERS PLAN OF CORRECTION  PRECINE  CROSS-REPERENCED TO THE APPROPRIATE  DEFICIENCY  FAG  PROVIDERS PLAN OF CORRECTION  PRECINE  CROSS-REPERENCED TO THE APPROPRIATE  DEFICIENCY  FAG  PROVIDERS PLAN OF CORRECTION  PRECINE  CROSS-REPERENCED TO THE APPROPRIATE  DEFICIENCY  FAG  PROVIDERS PLAN OF CORRECTION  PRECINE  CROSS-REPERENCED TO THE APPROPRIATE  DEFICIENCY  PROVIDERS PLAN OF CORRECTION  PROV	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICATI		(X2) M A. BUI		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG		06/1	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
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F 323	bedside table were fawas a bed pad alarm well as, the resident's position.  Interviews:  Following announcer 6/4/09, following his (Restorative Nursing interviews were condon to 6/4/09 at 3:45 PN about the resident's findicated the resident himself from his whe She indicated brought the resident likes to I lunch.  She was asked if resident himself resident likes to I lunch.  On 6/4/09 at 4:05 PN about the various alabed side table. She in interventions to be used the side table. She in interventions to be used the side table.	one of the resident's fall on return from the RNA Aide) dining room, several fucted on 6/4/09 and 6/5/09.  If, Employee #17 was asked fall following funch. She it apparently transferred elchair to his bed and fell. Sident suffered a faceration to eadded that the resident the seat belt and fell during  that the Restorative Aide back from funch and left him hallway. She mentioned that ay down in bed following  torative staff would know to noch, which she indicated that double double following the resident's indicated that those were new sed following the resident's also indicated the low bed	F	323			

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F 323	Continued From page	e 43	F	323	3		
	5/26/09, which was a indicated that she had that order.	t the Physician Order, dated in order for a bed alarm. She dn't had time to follow-up on					
		t the wheelchair seat belt rder. She indicated that she s an order for the					
	Employee #18, who #3, transported the relunch yesterday (6/4/	I, Employee #3 indicated that usually does not work Unit esident back to his unit after 09). She mentioned that the t aware that the resident er lunch.					
	aware of the resident after lunch. She ackn inform Employee #18	indicated that she was 's preference to lay down lowledged that she did not the resident's preference to She mentioned that her Units #1 and #2.					
	that she wheeled the and placed him outsid doorway. She indicat	1, Employee #18 indicated resident back to Unit #300 de of his room by the led that she was not aware of ence to lay down after lunch.					
		r indicated that she did not on the chair, just a self -					
	Resident #9						
	Resident #9 was 82 y	year-old female initially					

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	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	2	REET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	on 1/29/09, with diag Disorder, Chronic Ba Pain, History of Coro Post Percutaneous T Angioplasty, Diabete Documentation:  The facility's Monthly March, April and Mayincurred 3 falls (3/10/10) falls on 3/10/09 and abe isolated and no cliplan occurred.  Record review: It was noted in the R dated 2/5/09, that a president to receive platherapy to work with range of motion exerchair transfers, self cliving. It was also not placed on fall precaution. The RAP (Resident A Worksheet, dated 2/5/initial MDS assessment problem area due to secondary to her medicated the resident following dates and self-indicated the resident following dates and self-indicated and required an X-ramiddle finger.	y on 1/22/09, and readmitted noses including Anxiety lick Pain, Anemia, Chest mary Artery Disease, Status ransluminal Coronary s, and Hypothyroidism.  Incident/Accident Logs for y 2009 revealed the resident (709, 4/30/09, 5/10/09). The 4/30/09 were determined to hange to the resident's care ehabilitation Consultation, plan was initiated for the hysical and occupational strengthening activities, cises, bed mobility, bed to hare, and activities of daily led that the resident would be tionary measures.  Assessment Protocol) 5/09, following the resident's lent revealed falls to be a the resident's risk for falls dications and unsteady gait.	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295040	B. WING		06/	10/2009
	COVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	20	EET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Broken ribs.  Review of the X-ray rindicated an impress inferolateral rib fracture.  Review of the resider risk, dated 5/7/09, incompleted to a hindependent beyond ambulate by self, and contribute to falls.  Noted on the Care Pron 5/10/09. Additional resident diagnoses a medications as of the no evidence of the 3/4/30/09 documented.  The fall on 5/10/09 with plan, but no evidence of the 3/4/30/09 documented. There were two new following the fall on 5 reminders and a low indication of a psychiater review of the around the time of the low to floor bed. The indicated a clarification was dated on 5/28/05 fall recommendations.	right eye. 6:45 AM) and suffered results, dated 5/11/09, ion of at least one right are.  Int's Care Plan for Falls/Fall dicated the resident was a istory of falls, tries to be capabilities, tries to don medication that may  Ian was the documented fall all documentation included and current prescribed are care plan date. There was 10/09 fall and the fall on on the plan.  Ias documented on the care are of injury documented. Interventions implemented (5/10/09, which were frequent to floor bed. There was no interventions in and the post fall assessment.  In physician orders in and the fall indicated no order for physician order which on order for a low to floor bed and not at the time of the standard of the stand	F 323			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG		06/1	0/2009
	ROVIDER OR SUPPLIER PH TRANSITIONAL REH	ABILITATION CENTER	•	20:	EET ADDRESS, CITY, STATE, ZIP CODE 35 W. CHARLESTON BLVD. AS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	apparent fall occurre assessment that the however there was record for this interve bed in the resident's  The Facility Investigatindicated the result of determined to be an management action noted to be a Compusion at Valley Hospithat no change to the Review of the Post F5/10/09, indicated the transfer from bed to accident occurred. It assessment that the however there was rorder or intervention care plan prior to 5/1  The Facility Investigatindicated the result of determined to be an didn't use the call lig beyond her capabilitit taken was to place the bed, obtain a psychia her antidepressants, needed to routine.  There was no documphysician order for a review the use of the the 5/10/09. However	ate to the bathroom and the d. It was noted on the bed was in a low position, to documentation in the ention and evidence of low current care plan in place.  Ation Report, dated 4/30/09, of the investigation was isolated event. The taken to the incident was uterized Tomography (CT) ital. It was noted on the report e plan of care.  Ation Resort, dated de resident attempted to the was indicated on the bed was in a low position, to evidence of a physician documented in the current 0/09.  Ation Report, dated 5/10/09, of the investigation was impulsive act by the resident, and attempting tasks es. The management action he resident in a low to floor atric consultation related to and change Restoril from as	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		295040	B. WIN	1G _		06/1	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	·	:	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		5,200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	new order for Restori (every) hs (night). The through a medication Noted in a Social Ser was a conversation be and the resident. Seven the note concerning 5/10/09. The resident 20 minutes and no or go to the potty. I wait came." It was further yelled to them and no started to walk to the fell down."  Interview:  On 6/4/09 at 10:50 Placknowledged prior to used the call light, an and indicated that he to staff too. She indic came and she attemprestroom than fell hitt.  Next, the resident was when she bruised he did use the comentioned that she is during the night she is She was asked if staff.	lan, dated 5/7/09, noted a land and geometric approach was conducted review by the pharmacy.  vices note, dated 5/28/09, etween the Social Worker eral statements were noted go the resident's latest fall on estated, "I had my light on for the came to help me. I had to ed and waited and no one moted by the resident, "I to one came to help me so I bathroom on my own and I will be one the fall on 5/10/09, she do that started yelling out a roommate began to yell out ated after awhile, no staff of the dotted to get up to use the ing the wheelchair.  It is asked about her first fall or right eye. She indicated eall light to call staff. She is like an alarm clock and has to go to the bathroom. If check on her in the middle cated that they came in one	F	323			

TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) PLAN OF CORRECTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X4) PLAN OF CORRECTION (X5) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PLAN OF CORRECTION (X6) PLAN OF CORRECT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	295040	B. WIN	G		06/1	0/2009
	HABILITATION CENTER	•	2035	5 W. CHARLESTON BLVD.		<u> </u>
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL				JLD BE	(X5) COMPLETION DATE
Resident #10  Resident #10 was a admitted on 3/20/09 with diagnoses included Gastrostomy, Chrorn Disease, Convulsion without Behavior Distatus, Anemia, and Documentation revious Documentation in the Incident/Accident Lodocumented falls with documented falls with documented injury:  1). 3/22/09, during the valuation due to charge during the valuation due to charge falls with the second review:  Resident has had second review:	167 year-old male initially 10, and readmitted on 4/20/09, ading Attention to nic Obstructive Pulmonary 11 ns, Pneumonia, Dementia sturbances, Altered Mental of Seizure Disorder.  12 ne facility's Monthly 13 og revealed these of the early morning of status. 14 e early morning of status. 15 ne early morning of status. 16 e early morning of status. 16 e early morning of status. 17 nange of status. 18 everal admissions and of einitial admission to the of selow are the admission and of the resident: 18 no discharged on of and change of condition of status. 18 no discharged on of the selow are the admission and of the resident: 18 no discharged on of the selow are the admission and of the resident: 19 no and discharged on of the selow are the admission and of the resident: 19 no and discharged on of the selow are the admission and of the resident: 19 no and discharged on of the selow are the admission and of the resident: 19 no and discharged on of the selow are the admission and of the resident: 19 no and discharged on of the selow are the admission and of the resident: 19 no and discharged on of the selow are the admission and of the resident: 19 no and the resident of the selow are the admission and of the resident: 19 no and the resident of the selow are the admission and the resident: 19 no and the selow are the admission and the resident: 19 no and the selow are the admission and the resident: 19 no and the selow are the admission and the resident: 19 no and the selow are the admission and the resident: 19 no and the selow are the admission and the resident of the selow are the admission and the resident of the selow are the admission and the selow are the admissio	F	323			
resident was a fall r	isk related to functional					
	CORRECTION  COVIDER OR SUPPLIER  H TRANSITIONAL REI  SUMMARY S (EACH DEFICIEN REGULATORY OF PARTICIPATION OF	CORRECTION  295040  OVIDER OR SUPPLIER  H TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 48  Resident #10  Resident #10  Resident #10  Resident #10  Outlined From page 48  Resident #10  Resident #10  Resident #10  Resident #10  Resident #10  Designation of the state	OVIDER OR SUPPLIER  H TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 48  Resident #10  Resident #10 was a 67 year-old male initially admitted on 3/20/09, and readmitted on 4/20/09, with diagnoses including Attention to Gastrostomy, Chronic Obstructive Pulmonary Disease, Convulsions, Pneumonia, Dementia without Behavior Disturbances, Altered Mental Status, Anemia, and Seizure Disorder.  Documentation review:  Documented falls with no evidence of documented falls with no evidence of documented injury: 1). 3/22/09, during the early morning 2). 3/24/09, during the evening and sent out for evaluation due to change of status. 3). 4/9/09, during the early morning 5). 4/15/09, during the early morning 5). 4/15/09, during the evening and sent out 2 days later for left arm weakness.  Record review:  Resident has had several admissions and discharge since the initial admission to the facility on 3/20/09. Below are the admission and discharge dates of the resident: 1). Admitted on 3/20/09 and discharged on 3/25/09 due to a fall and change of condition 2). Readmitted on 3/31/09 and discharged on 4/17/09 due to left arm weakness 3). Readmitted on 4/20/09  Review of the resident's Care Plan for physical mobility, impaired, dated 4/7/09, indicated the	OVIDER OR SUPPLIER  H TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 48  Resident #10  Resident #10 was a 67 year-old male initially admitted on 3/20/09, and readmitted on 4/20/09, with diagnoses including Attention to Gastrostomy, Chronic Obstructive Pulmonary Disease, Convulsions, Pneumonia, Dementia without Behavior Disturbances, Altered Mental Status, Anemia, and Seizure Disorder.  Documentation in the facility's Monthly Incident/Accident Log revealed these documented falls with no evidence of documented injury: 1). 3/22/09, during the early morning 2). 3/24/09, during the early morning 4). 4/10/09, during the early morning 5). 4/15/09, during the early morning 5). 4/15/09, during the evening and sent out 2 days later for left arm weakness.  Record review:  Resident has had several admissions and discharges since the initial admission to the facility on 3/20/09. Below are the admission and discharge dates of the resident: 1). Admitted on 3/20/09 and discharged on 3/25/09 due to a fall and change of condition 2). Readmitted on 4/20/09  Review of the resident's Care Plan for physical mobility, impaired, dated 4/7/09, indicated the	OVIDER OR SUPPLIER  H TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)  Continued From page 48  Resident #10 was a 67 year-old male initially admitted on 3/20/09, and readmitted on 4/20/09, with diagnoses including Attention to Gastrostomy, Chronic Obstructive Pulmonary Disease, Convulsions, Pneumonia, Dementia without Behavior Disturbances, Altered Mental Status, Anemia, and Seizure Disorder.  Documentation in the facility's Monthly Incident/Accident Log revealed these documented falls with no evidence of documented falls with no evidence of documented injury:  1) 3/22/09, during the early morning  2) 3/24/09, during the early morning  4), 4/10/09, during the early morning  4), 4/10/09, during the early morning  5), 4/15/09, during the early morning  4), 4/10/09 during the early morning  7), 4/16/09 during the early morning  8), 4/16/09 during the early morning  1), 4/10/09 during the early morning  1), 4/10/09 during the early morning  2), 6/16/09 Selow are the admissions and discharged also of the resident:  1), Admitted on 3/20/09 and discharged on 3/26/09 due to a fall and change of condition  2), Readmitted on 3/31/09 and discharged on 4/17/09 due to left arm weakness  3), Readmitted on 4/20/09  Review of the resident's Care Plan for physical mobility, impaired, dated 4/7/09, indicated the	OVIDER OR SUPPLIER  295040  STREET ADDRESS, CITY, STATE, ZIP CODE 2335 W. CHARLESTON BLVD.  LAS VEGAS, NY 89102  SUMMANY STATEMENT OF DEFICIENCES GEAR DEFICIENCY SIDE OF RECORD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 48  Resident #10  Resident #10 was a 67 year-old male initially admitted on 3/20/09, and readmitted on 4/20/09, with diagnoses including Attention to Gastrostomy, Chronic Obstructive Pulmonary Documentation in the facility's Monthly Incident/Accident Log revealed these documented falls with no evidence of documented injury:  1), 3/22/09, during the early morning 2), 3/24/09, during the evening and sent out 12 days later for left arm weakness.  Record review:  Resident has had several admissions and discharge dates of the resident:  1), Admitted on 3/20/09 and discharged on 3/25/09 due to a fall and change of condition 2), Readmitted on 3/20/09 and discharged on 3/25/09 due to a fall and change of condition 2), Readmitted on 3/20/09 and discharged on 4/17/09, indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		295040	B. WING	<del></del>	06/	10/2009	
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	2	REET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. .AS VEGAS, NV 89102	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Alzheimer Dementia. documentation of evifalls on 3/22/09 and 3 resident to be transfer. Review of the Care F 4/15/09, indicated the related to impulsive to independent beyond Alzheimer Dementia. could contribute to far Review of the Care F to Alzheimer Disease resident was a fall risindications noted in the there was no update with the five falls the any new intervention future falls.  Further review of the care plans had no evresident incurred dur (3/22/09, 3/24/09) and (4/9/09, 4/10/09, 4/18) indication of change possibly prevent furth. An attempt to review Assessments for each was no evidence of the fall.  Interview:	t, and has diagnosis of There was no dence of the two previous 3/24/09, which required the erred out for evaluation.  Plan for Falls/Fall Risk, dated e resident was a fall risk behaviors, tries to be capabilities, unsteady gait, and medications which alls.  Plan for Falls/Fall Risk related e, dated 5/4/09, indicated the ek due to the same the above 4/15/09 plan. Again to the resident's care plan resident has incurred and to the possibility of  two above aforementioned ridence of five falls the ing the previous admission did the current admission 5/09). There was no with interventions that would	F 323				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG_		06/16	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE . DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 323	indicated that there we resident's falls. She as reported injuries due  Employee #12 furthe interview that the postacility in determining care planning process accidents.  Resident #13  Resident #13 was a sto the facility on 1/7/02/21/09 to Nathan Accidagnoses including I Specified, Hyperlipide Fracture/Repair, Dep Disease, Dysphagia	s as of this date. She was no pattern to the added that there were no to the falls.  In indicated during the st fall assessments assist the new approaches during the st to prevent future falls or  22 year-old female admitted 19, and discharged on lelson Hospice, with Hypertension Not Otherwise emia, Status Post Right Hip ressive Disorder, Parkinson Not Otherwise Specified, emia, Osteoporosis Not	F	323			
	the resident incurred documented evidenc 1). 1/16/09 during the 2). 2/12/09 during the unattended in the din Review of the resider risk, dated 1/14/09, ir risk for falls due to his Parkinson, Depression	e evening shift e evening shift while left					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		295040	B. WING		06	/10/2009	
	OVIDER OR SUPPLIER  THANSITIONAL RE	HABILITATION CENTER	203	ET ADDRESS, CITY, STATE, ZIP CODE 5 W. CHARLESTON BLVD. S VEGAS, NV 89102		710/2003	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 323	orders for X-rays of lumbar spine series the resident in a low Further review of the documentation of the 2/12/09, and both was no evidence of documented on the of the care plan revichange in plan of chowever physician low bed order.  Review of the Post 1/16/09, indicated the resident's activity of the resident's room assessment that the prior to the fall. An following the resident wheelchair in the doccurred.  The facility's Investindicated the resident the side of the resident that the prior to the fall.	r, dated 1/16/09, revealed if the resident's lateral hip, s, fall precautions, and place w bed.  The Care Plan revealed wo falls on 1/16/09 and were noted as no injury. There is new interventions a care plan. The second page realed documentation of "no are" for 1/16/09 and 2/12/09, orders on 1/16/09 revealed a  Fall Assessment, dated the facility was unaware of the uring the fall which occurred in . It was indicated in the resident was in a low bed order for low bed was written	F 323				
	to the facility on 4/3 Left Sided Weakne	a 55 year-old female admitted 0/09, with diagnoses including ss, Recurrent, Secondary to vascular Accident, History of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		295040	B. WIN	IG		06/1	0/2009	
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	·	20:	EET ADDRESS, CITY, STATE, ZIP CODE 35 W. CHARLESTON BLVD. AS VEGAS, NV 89102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	Acute renal Failure ar on Hemodialysis, Star Pneumonia, Fungal Diabetes, Hypertensic Swelling.  Record review:  Review of the three P contained in the record incurred three falls du (5/4/09, 5/11/09,5/17/in the resident's bedro transfer.  Review of the two Ca dated 5/4/09 and 5/7/the resident had incur 5/4/09, noted the first 5/11/09. Following the noted on the plan that implemented sideralls reminders to ask for a following the second interventions or approfuture falls.  The second Care Pla resident's third fall on	nd Chronic Kidney Disease tus Post Aspiration Dermatitis, History of on, and Left Upper Extremity  Post Fall Assessments and indicated the resident uring the month of May 2009 (709). All three falls occurred from while attempting to  The Plans for Risk of Falls, (709, noted all three falls that the facility had be resident's initial fall, It was to the facility had as an enabler and frequent assistance. The intervention fall was a X-ray due to the ce on the floor. There was ditional or different to baches which may prevent on the floor. Interventions noted	F	323				
	the resident new glas the second page of the	le an eye examination to get uses. A second notation on the plan was on 5/20/09, the plan of care.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	G		06/10/2009	
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 323	the facility on 5/2/09, Congestive Heart Fai Specified, Insomnia, Spasm of Muscle, Hy Amputee Below Left I Post Amputee Other Uncontrolled.  Documentation review Review of the facility's Log for May 2009, including two falls soon after hit falls (5/7/09, 5/8/09) owas in his room. The corrective actions con Record review:  Review of the initial F 5/2/09, rated the resid (10 and above is high incurred an amputation fourth toe to left foot wamputations as noted Progress Note during Review of the two Cadated 5/7/09 and 5/12 facility approaches with noted following the set The Care Plan, dated approach was to main position". However, it Order on 5/28/09 to pued for safety" and "a	S9 year-old male admitted to with diagnoses including lure Not Otherwise Acquired Hypothyroidism, repertension, Status Post Knee, Gangrene, Status Toe, and Diabetes Mellitis II  W:  S Monthly Incident/Accident dicated the resident incurred s admission on 5/2/09. Both occurred while the resident log did not contain any responding to the two falls.  Fall Risk Assessment, dated dent with a total score of "5" in risk). The resident has a on below the right knee and with indications of additional in a 6/1/09 Doctor's a wound follow-up visit.  The Plans for Risk for Falls, 1/09, indicated various ith no new interventions	F	323			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		295040	B. WIN	G		06/1	0/2009	
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	·	20	EET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. AS VEGAS, NV 89102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	Further review of the any new changes or fall and after the new Resident #24  Resident #24 was at to the facility on 9/17 Cellulitis Not Otherw Disorder, Mental Dis Otherwise Specified Arthritis, restless Legantibiotics, Shortnes Reflux, Hyperlipider and Osteoporosis Notes Record review:  Review of the facility admission on 9/17/0 resident had incurred 1). 10/19/08, during to 3/10/09, during the complained of heada 5). 4/27/09, during the skin tear. 6). 5/20/09, during the Review of the resided 12/24/08, noted falls 10/19/08, 3/10/09, 3/	bollowing the second fall.  be both plans did not indicate updates following the second of physician orders on 5/28/09.  by 88 year-old male admitted 1/08, with diagnoses including rise Specified, Depressive order, Hypertension Not, Legal Blindness, rheumatoid ground Syndrome, Long-Term Uses of Breath, Esophageal nia Not Otherwise Specified, of Otherwise Specified.  by Syndrome injuries: day shift and some injuries: day shift and some injuries: day shift and hit head and ache sent for head X-rays. The evening shift and suffered the day shift and suffered the resident incurred on 1/21/09, and 4/27/09. The care dates following the falls on	F	323				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	G		06/1	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	<b>!</b>	203	ET ADDRESS, CITY, STATE, ZIP CODE 35 W. CHARLESTON BLVD. AS VEGAS, NV 89102		57200
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 323	Further review of the page indicated no ne occurred following the after the resident's faintervention indicated reminders to ask for a the second page of the second page of the resident's skin tear.  Policy review:  It was indicated in the that the facility would of falls and to follow-to assess the resident indicated that the assidentify the reason for the preparation of a preduce the potential following any fall or in health professional."  It was documented usubsection of the facility and approaches to reprocedure #20 updated, post fall, ideand approaches to reprocedure #14, "the Assessment" will be onurse within 24 hours contributing factors to	plan revealed on the second w changes or updates e early falls until seven days II on 4/20/09. The I was "frequent verbal assistance." Also, noted on the plan was treatment to the e facility's Fall Prevention assess resident for the risk up and evaluate falls in order at's condition. It further the fall and would assist in plan of care which could for future falls.  The purpose subsection of sidents would receive a and treatment immediately nijury by the appropriate  Inder the procedure falls and goals aduce the potential of future falls and goals aduce the potential of future	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	G		06/1	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REHA	ABILITATION CENTER	•	2035 W	DDRESS, CITY, STATE, ZIP CODE . CHARLESTON BLVD. EGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323 F 333 SS=D	the "Post Fall Assess improve the resident's 483.25(m)(2) MEDIC.	ment" review will be used to s fall prevention plan. ATION ERRORS  ure that residents are free of		323			
F 371 SS=F	by: Based on observation review, the facility fail pass was free of erro Findings include: The medication error An unsampled reside Physician's Order dat milligrams (mg) via gaday.  During the morning m #13 omitted giving La 6/3/09. 483.35(i) SANITARY The facility must - (1) Procure food from considered satisfacto authorities; and	rate was 2.2  Int in Room 109A had a red 5/3/05 for Lasix 40 restrostomy tube every other redication pass, Employee resix 40 mg which was due on CONDITIONS  I sources approved or rry by Federal, State or local restribute and serve food	F:	371			

1, 7	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	295040	B. WIN	G		06/1	0/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITY	TATION CENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 135 W. CHARLESTON BLVD. AS VEGAS, NV 89102		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371 Continued From page 57 This REQUIREMENT is no by: Based on observation and failed to store, prepare and sanitary conditions.  Findings include:  On the morning of 6/2/09, deficiencies were noted due the kitchen:  1. The kitchen staff did not test the quaternary ammore three compartment sink us sanitize pots and pans. The using a chlorine tester to the ammonium.  2. When the chlorine sanitested for residual chlorine parts per million (ppm). The dishwasher several time indication of residual chlore wash and sanitize cycle.  Note: The dishwasher was above 50 ppm later that me above 50 ppm later that me acceptable, cleanable mate cleaning the pots and panse acceptable, cleanable mate cleaning the pots and panse 483.60(b), (d), (e) PHARM.  The facility must employ of a licensed pharmacist who of records of receipt and desired.	the following uring the initial tour of the kitchen staff was test for quaternary distributed below 50 he kitchen staff tested mes without any rine levels after the set and tested and tested morning.  The compartment sink was as and not with terial for plugs, while as and not with the services of the compartment as a system.		371			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
			A. BUILDIN						
		295040	B. WING _		06	/10/2009			
	ROVIDER OR SUPPLIER PH TRANSITIONAL REHA	ABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP COD 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102	E				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 431	records are in order a controlled drugs is m reconciled.  Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable.  In accordance with S facility must store all locked compartments controls, and permit to have access to the keep to be a controlled drugs listed controlled drugs listed controlled drugs listed control Act of 1976 a abuse, except when a package drug distributed and the package drug	and that an account of all aintained and periodically are used in the facility must be a with currently accepted as, and include the y and cautionary expiration date when tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to ays.  Tride separately locked, compartments for storage of d in Schedule II of the y Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the aimal and a missing dose can are is not met as evidenced ans, interviews and recordailed to ensure drugs and ed, labeled and controlled	F 43						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		295040	B. WIN	IG _		06/1	0/2009
	ROVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	found to be deficient:  1. The 100 Hall Mediat 3:00 PM on 6/2/09  -The Narcotic Lorefrigerator was unsequived 10 pre-filled milligrams (mg) per rundated 2 mg vial of  -The temperature degrees Farenheit.  -The refrigerator multi-use bottle of Tu  - Four cans of G stored on a shelf with 2009.  2. The 200 Hall Mediat 4:00 PM on 6/2/09  -A multi-use bottle of medication room refrigeration date of medication room refrigeration and the stored on a shelf with 3. The 300 Hall Mediat 5:00 PM on 6/2/09  -The Narcotic Bottle of Tu	ation storage issues were ication Room was inspected cock Box located in the ecured. The box contained syringes of Lorazepam 2 milliliter (ml) and one open Lorazepam. The of the refrigerator was 34 The contained one open undated aberculin PPD. Flucerna 1.2 calories were the expiration dates of June 1, Ilication Room was inspected the of Influenza Vaccine with 10/4/08 was stored in the digerator. The company of the interest of the properties	F	431			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		295040	B. WIN	IG		06/1	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 035 W. CHARLESTON BLVD. .AS VEGAS, NV 89102	,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 431	Continued From pag	e 60	F	431			
	4. On 6/4/09, during pass on the 100 Hall mg per 15 ml was ob when the bottle was  5. On 6/4/09, the 100	Varcotic Box contained 30 ectable Lorazepam 2 mg/ml.  the morning medication , a bottle of Stool Softener 60 eserved as having no date opened.  O Hall Medication Cart: box of Morphine Sulfate					
	injectable 2 mg/ml th were 5/1/09.  - A vial of Lorazonesident had an expionate an expionate of 5/9/09.  - The medication	e expiration date on the vials epam for an unsampled ration date of 4/24/09. of Lorazepam 5 mg by mouth sident had an expiration date  ns Zolpidem Tartrate, OxyIR r three unsampled residents					
	the resident received 4/6/09, 4/11/09, 4/12 were given), 5/10/09 5/31/09. As of 5/31/0	ontrol Drug Record indicated I Lorazepam 1 mg tablets on 1/09, 4/27/09, 4/27/09 (2 mg , 5/11/09 5/23/09, 5/24/09, 19, the medication resident's Lorazepam 1 mg					
	Resident #11 indicat mg on 4/6/09 and 2 i 4/11/09 and 4/12/09 The Medication Adm Resident #11 indicat Lorazepam for the m	inistration Record for ed he received Lorazepam 1 mg on 4/27/09. The doses for were not documented. inistration Record for ed he did not receive any onth of May 2009.  rning, the Director of Nursing					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION (X3) DATE SU COMPLET		
		295040	B. WIN	IG		06/1	0/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			•	STREET ADDRESS, CITY, STATE, 2035 W. CHARLESTON BLVD LAS VEGAS, NV 89102			
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	were supposed to be Boxes for each of thr sign off to the on con The Nurse Superviso the boxes to the on con Both Nurse Supervison signing off on the, "Flocated in each Medion on 6/3/09, the "Floor and the "Floor Narco Secured" were review Room. There were usheets on all three floor November 2008 to More the Nurse Supervison sheets. She indicated Release Narcotic Bobe used for all Medion She indicated the Nurse Supervison sheets. She indicated Release Narcotic Bobe used for all Medion She indicated the Nurse to check the bod daily.  On 6/3/09, the DNS is 23 vials of unopened the 300 Hall Supervison should not have been stored on the 300 Haresidents who receive the 100 Hall.  On 6/4/09 in the mor Quality Nurse and the Pharmacy contracted interviewed. The Quainspected the Medica Medication Carts on	ated the Nurse Supervisors checking the Narcotic dee Medication Rooms and aning Nurse Supervisor daily. The same to give the keys for coming Nurse Supervisor. The same to give the keys for coming Nurse Supervisor. The same to give the keys for coming Nurse Supervisor. The same to give the keys for coming Nurse Supervisor. The same to be cloor Narcotic Release sheet," The same to give the keys for coming Nurse Supervisor. The same to be cloor Narcotic Release sheets The same to give the keys tic Release Narcotic Box wed for each Medication ansigned spaces on the cloors (units) that dated from clay 2009. The DNS indicated the swere not using the correct to that the, "Floor Narcotic to Secured" was the form to cation Room Narcotic Boxes. The same to give the sheets  The same to give the keys for to give the same to give to give the same to give the keys to give the secure to gi	F	431			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET				
		295040	B. WIN	IG_		06/1	0/2009	
NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			•	STREET ADDRESS, CITY, STATE, ZIP CO 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 431	the narcotic reconcilia the Medication Room in-service was given concerning the "Medithat in-services were monthly and no one of the indicated it was the roto hand write the exp substances for individual. He indicated he were legible.  The Facility Policy for 7/04, indicated the for "Drugs listed as Schestored in a double-loof for that purpose, sep access keys to control same keys giving access medication nurse on of a key to controlled Schedules III-V may the same as all other	the deficient practices with ation, the medications and as. She indicated an at the facility on 5/21/09, ication Pass." She indicated conducted at other facilities comes from this facility.  pharmacy company esponsibility of the pharmacy iration dates for controlled dual residents per Nevada would make sure the dates	F	431				
F 441 SS=E	infection control prog safe, sanitary, and co to prevent the develo disease and infection an infection control p investigates, controls	IN CONTROL  Ablish and maintain an	F	441				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		DING (X3) DATE SU  COMPLET		
		295040	B. WIN	IG _		06/1	0/2009
	OVIDER OR SUPPLIER  PH TRANSITIONAL REH	ABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	resident; and maintal corrective actions rel  This REQUIREMENT by: Based on observation review, the facility fait technique was follow changes for three sa #11) and one unsame Findings include:  On 6/2/09 at 1:30 PN tracheostomy (trach) Employee #7 and an Employee #7 contamusing her gloves to othat was on the beds not don a new pair of the cannula into the incomplete the cannula into the incomplete the cannula into the incomplete the seriesident #11's trach Respiratory Therapis contaminated the steresident's drawer to be incorrective actions and incorrections.	pplied to an individual ins a record of incidents and ated to infections.  It is not met as evidenced in, interview and document led to insure sterile ed during tracheostomy tube impled (Residents #5, #6 and pled resident.  If an unsampled resident's tube was changed by other Respiratory Therapist. Initiated the sterile field by pen the box of the cannula ide stand. Employee #7 did if gloves when she inserted resident's tracheostomy.	F	441			
	cannula box that was bedside table. Emplo the clean cannula int changing his gloves.	s sitting on the resident's byee #8 proceeded to place o the resident's tach without					
	trach tube for Reside Respiratory Therapis						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X3) DATE SUI COMPLET			
	295040	B. WIN	G		06/1	0/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CO 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		•	
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
outside of the gloves wi Policy Review:  The Tracheostomy Tub- indicated, gloves should setting up the equipmer after set up in order not field.  F 520 483.75(o)(1) QUALITY ASSURANCE  A facility must maintain assurance committee or nursing services; a phys facility; and at least 3 of facility's staff.  The quality assessment committee meets at lea issues with respect to w and assurance activities develops and implement action to correct identified.  A State or the Secretar disclosure of the record	cannula that was on the with gloves. She clean cannula into the her gloves.  Iloyee #9 changed the #5 with another Employee #5 e field when she touch the th her ungloved hands.  The Change Policy (no date) to be changed twice while not a Gloves are donned to contaminate the sterile to conta		520			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET			
		295040	B. WIN	1G		06/1	0/2009
	OVIDER OR SUPPLIER  THANSITIONAL REH	ABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 520	and correct quality de a basis for sanctions.  This REQUIREMENT by: Based on observation	section.  by the committee to identify efficiencies will not be used as	F	520			
	assessment and assi and implemented app to correct identified q areas of respiratory to services, identifying s Services.	urance activities developed propriate and effective plans uality deficiencies in the herapy, falls, pharmacy sexual abuse and Social					
	responsible for trache small volume nebuliz ventilator settings, re trach tubes and other respiratory care at the	e facility. The Director of (DRT) indicated on 6/5/09,					
	(DNS) indicated she invite the DRT to bed Quality Committee duresidents with respirar 2. Due to the high vo	lume of falls and accidents, e process had not been					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET				
		295040	B. WIN	G		06/1	0/2009
NAME OF PROVIDER OR SUPPLIER  ST JOSEPH TRANSITIONAL REHABILITATION CENTER  SUMMARY STATEMENT OF DESIGNATES				20	EET ADDRESS, CITY, STATE, ZIP CODE 35 W. CHARLESTON BLVD. AS VEGAS, NV 89102		57200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 520	program to prevent far Tag F323.)  3. The medication issexperienced to include medications, medicate refrigerated narcotic in not locked, expired moreoms, the medication opened medications sheet reconciliations documentation that we were addressed and Nurse from the facility since the beginning of Despite these recommendations at the Quality Assurance (F431.)  The Consultant Pharmindicated, "5. Submedicated, "5. Submedi	nentation and monitoring a tills and injuries. (Also see uses the facility had e, the storage of ion rooms not locked, toxes either not secure or redication in the medication in refrigerator temperatures, not dated and the narcotic heets that contained ras illegible. These issues documented by the Quality ras contracted pharmacy for the year in January 2009. The facility rese deficient practices. The refrigerator temperatures, not dated and the narcotic heets that contained ras illegible. These issues documented by the Quality rate of the year in January 2009. The facility rese deficient practices. The refrigerator temperature and the research of the process. (Also see Tag macist revised 7/04, it a written report at each urance and Assessment ummarizing the status of the cal service and nursing staff bmit a monthly report that lural observations,	F	520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	295040	B. WING			/40/2000	
NAME OF PROVIDER OR SUPPLIEF ST JOSEPH TRANSITIONAL	1	2035	T ADDRESS, CITY, STATE, ZIP CODE S W. CHARLESTON BLVD. S VEGAS, NV 89102		710/2009	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL LY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
the Social Service difficult family mon-compliant o	led to include the resources of the Department to work with embers, residents who are residentified as having haviors. (Also see Tags F223)	F 520				